No. 89-941

JAN 12 1990

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE AMERICAN COLLEGE OF RADIOLOGY AND THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-941

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The American College of Radiology and the American Medical Association respectfully move for leave to file the attached brief *amicus curiae.* Petitioners have consented to the filing; respondent has not.[1]

---

[1] Respondent refused to consent unless the *amicus* brief contained specific statements concerning the involvement of the local chapter of the American College of Radiology in the proceedings below. The specific statements demanded by respondent are potentially misleading. This same issue was litigated in the Second Circuit, which granted a contested motion of the American College of Radiology to participate as *amicus curiae.* In any event, respondent does not appear to have any objection to the participation here of the American Medical Association. (Copies of the letters from both petitioners and respondent are on file with the Clerk.)

The American College of Radiology is a not-for-profit professional association of approximately 20,000 physicians who are specialists in radiology.[2] The purposes of the College are to advance the science of radiology, improve radiologic service to the patient, study the socioeconomic aspects of the practice of radiology, and encourage improved and continuing education for radiologists and allied professionals.

The American Medical Association ("AMA") is a private, voluntary nonprofit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and the improvement of the public health. Its membership exceeds 280,000 physicians and medical students.

Amici are dedicated to promoting the public welfare through the maintenance of appropriate professional standards and the provision of quality health care. A competitive market is essential to the efficient delivery of the health care services needed by the public. Preservation of competition in the marketplace depends upon vigorous enforcement of the antitrust laws. *Amici* believe that the Court of Appeals' decision in this case inappropriately permits harm to the competitive process in violation of those laws.

The decisions of the courts below have nationwide ramifications with respect to the ability of dominant medical insurers to use their market power to insulate themselves from price competition in the markets in which they purchase services for their subscribers. Respondent in this proceeding, Empire Blue Cross and Blue

---

[2] Diagnostic radiologists make expert interpretations of studies made under their direction, including radiographs, fluoroscopies, ultrasound and nuclear radiology scans, computerized tomographic ("CT") and magnetic resonance imaging ("MRI") studies. These interpretations often form the primary basis for definitive medical treatment. Therapeutic radiologists treat, and in many cases cure, malignancies.

Shield, possesses such market power, and it is the position of *amici* that respondent has abused that market power through the practice at issue in this case. If adopted by other courts, the Court of Appeals' decision could lead to similar harm to physicians and the public elsewhere. *Amici* seek to participate in this proceeding to urge the Court to grant the petition for certiorari and to restrain respondent's improper exercise of market power.[3]

For all the foregoing reasons, *amici* urge the Court to accept and file the attached brief *amicus curiae*.

Respectfully submitted,

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record

---

[3] These same concerns, and a legitimate, direct interest in the ability of radiologists to be free to offer their services in a competitive environment, have motivated the local chapter of the American College of Radiology to serve as an organizational vehicle for petitioners in identifying counsel for and funding this action.

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICI	1
INTRODUCTION	1
REASONS FOR GRANTING THE WRIT	6
I. THE DECISIONS BELOW IGNORE THE CRITICAL DISTINCTION ESTABLISHED BY THIS COURT BETWEEN UNILATERAL AND COLLECTIVE ACTION AND ENDORSE AN IMPROPER EXERCISE OF MARKET POWER	7
II. THE COURT SHOULD GRANT THE PETITION TO RESOLVE THE CONFLICT IN THE CIRCUITS OVER THE LEGALITY OF MONOPOLY "LEVERAGING"	13
CONCLUSION	16

TABLE OF AUTHORITIES

Cases: Page

Albrecht v. Herald Co., 390 U.S. 145 (1968) 12
Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) 13
Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585 (1985) 14
Association of Intercollegiate Athletics for Women v. National Collegiate Athletic Assn., 735 F.2d 577 (D.C. Cir. 1984) 15
Barry v. Blue Cross of California, 805 F.2d 866 (9th Cir. 1986) 10
Berkey Photo v. Eastman Kodak Co., 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980) 14
Brillhart v. Mutual Medical Insurance, 768 F.2d 196 (7th Cir. 1985) 9
Calnetics Corp. v. Volkswagen of America, Inc., 532 F.2d 674 (9th Cir.), *cert. denied*, 429 U.S. 940 (1976) 12
Catlin v. Washington Energy Co., 791 F.2d 1343 (9th Cir. 1986) 15
Consul v. Transco Energy Co., 805 F.2d 490 (4th Cir.), *cert. denied*, 481 U.S. 1050 (1986) 15
Eastern States Retail Lumber Dealers' Assn. v. United States, 234 U.S. 600 (1914) 12
Fishman v. Estate of Wirtz, 807 F.2d 520 (7th Cir. 1986) 15
Grenada Lumber Co. v. Mississippi, 217 U.S. 433 (1910) 12
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) 10
Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2 (1984) 8, 9
Kartell v. Blue Shield of Massachusetts, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) 9, 11, 13
Kerasotes Michigan Theatres v. National Amusements, 854 F.2d 135 (6th Cir. 1988) 15
Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959) 7

TABLE OF AUTHORITIES—Continued

	Page
Lorain Journal Co. v. United States, 342 U.S. 143 (1951)	14
Mandeville Island Farms v. American Crystal Sugar Co., 334 U.S. 219 (1948)	8, 12
Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut, 675 F.2d 502 (2d Cir. 1982)	9
Royal Drug Co. v. Group Life and Health Insurance Co., 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985)	10
United States v. Paramount Pictures, Inc., 334 U.S. 131 (1948)	12
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 659 F. Supp. 132 (S.D.N.Y. 1987)	5
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 707 F. Supp. 708 (S.D.N.Y. 1989)	*passim*
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 884 F.2d 707 (2d Cir. 1989)	5
Miscellaneous:	
Radiology Practice Survey, American College of Radiology, Reston, Va. (1983)	2
Radiology Billing Practice Survey, American College of Radiology, Reston, Va. (1987)	3
R. Posner & F. Easterbrook, *Antitrust* 4-10, 148-150 (1981)	12

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-941

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF OF THE AMERICAN COLLEGE OF RADIOLOGY AND THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF AMICI

The interest of *amici* is described in the accompanying Motion for Leave to File Brief *Amicus Curiae*.

INTRODUCTION

Since the late 1960s, radiologists—like anesthesiologists, pathologists, and other medical specialists who typically provide services in hospital settings—increasingly have offered their services as independent contractors, rather than as hospital employees. A study performed for the American College of Radiology in 1983 found that 80.3% of all practicing radiologists were compensated

primarily on a fee-for-service basis, while only 2.8% were reliant primarily upon either a percentage or a lease arrangement with a hospital.[1] In those cases in which a radiologist establishes an independent practice, bills for radiology services generally are paid by insurers that offer coverage for the services of *physicians*, rather than by insurers that offer coverage for *hospital* services.

Respondent Empire Blue Cross and Blue Shield is a health insurance corporation offering services in portions of New York. Empire offers two basic insurance plans: "Blue Cross," which covers certain defined *hospital* services and benefits, and "Blue Shield," which covers medical services provided by *physicians*.[2] Over 80% of the approximately 11 million people who live in the 17 counties in the metropolitan New York City area subscribe to respondent's "Blue Cross" insurance plan for hospital services. In contrast, less than a third of those 11 million people subscribe to respondent's "Blue Shield" plan for physician services, and instead subscribe to other medical insurers.

At issue in this case is an arrangement through which respondent obtains professional radiology services for Blue Cross subscribers in the 17 downstate counties. In essence, if a hospital wishes to be eligible to treat Blue Cross subscribers and to receive reimbursement from respondent, the hospital (1) must agree to accept an established payment from Blue Cross as full reimbursement for the covered services provided, and (2) must

---

[1] *Radiology Practice Survey 1983*, American College of Radiology, Reston, Va. (1983). Although 17% of the practicing radiologists received salary compensation, 80% of these physicians were employed in government hospitals or other facilities in which patients do not pay for professional services.

[2] "Blue Cross" and "Blue Shield" simply are types of insurance coverage offered by respondent. They are not separate economic entities; they do not represent different divisions or departments within the company.

agree to include the professional services of radiologists within those covered services paid (exclusively) by Blue Cross.

No other Blue Cross plan in the country requires the professional services of radiologists to be included in the services provided to hospital inpatients. Similarly, the Blue Shield policy provided by respondent is the only insurance plan offered by a private insurance carrier offering general coverage for physicians' services (including other Blue Shield plans) that does not include coverage for the professional services of radiologists to hospital inpatients. In other words, so far as *amici* are aware, respondent is the only health benefit insurer in the country that insists on covering professional radiology services as part of a *hospital* benefit insurance plan.[3]

Through the billing arrangement at issue here, respondent merges the distinct product markets in this locale for hospital and radiology services. In the words of the District Court, "Blue Cross insists that hospitals that contract with Blue Cross continue to offer radiology services to Blue Cross subscribers as part of a *package* of hospital services." *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 707 F. Supp. 708, 710 (S.D.N.Y. 1989) (emphasis supplied), *reprinted in* Petitioners' Appendix ("A") at A-6, A-9. *See also* 707 F. Supp. at 710 (A-10) (Blue Cross "us[es] its bargaining power to purchase radiology services as part of a *bundle* of hospital services") (emphasis supplied). As

---

[3] A 1987 survey conducted by the American College of Radiology of insurance practices in all 50 states revealed that in no state other than New York did any insurer, including other Blue Cross and Blue Shield providers, attempt to prohibit radiologists from establishing an independent practice and billing a patient (or the patient's *physician* service insurer) for professional services. *Radiology Billing Practice Survey*, American College of Radiology, Reston, Va. (1987).

summarized by the court:

> [I]f [the hospitals] wish to sell to Blue Cross, they must sell Blue Cross the package it wants to buy, and they must agree that the price charged to Blue Cross will be the only charge for the services.

707 F. Supp. at 713 (A14).

Blue Cross is able to secure this arrangement only through its dominant position as the insurer for most hospital service claims. Hospital executives testified that, although they would prefer not to include radiology services as covered *hospital* services, they have no choice but to accede to Blue Cross' demands.[4] Indeed, the hospitals rejected requests for similar arrangements made by other, smaller insurers.[5]

The "bundling" arrangement compelled by Blue Cross through use of its monopoly power has two significant effects. First, in the competitive market for the sale of insurance to cover claims for physician services—which is equivalent to the competitive market for "the opportunity to buy" such services on behalf of subscribers—respondent is able to use its dominant position in the market for *hospital* services to secure a virtually exclusive franchise to provide coverage for radiology services that it otherwise could not obtain. Second, radiologists are foreclosed from selling their services in a more competi-

[4] Evidence in the record establishes that hospitals prefer radiologists, and other hospital-based physicians, to practice as independent contractors because (1) the hospital no longer has to pay a salary to the physician, (2) the fee income generated by the physician is utilized in part to buy equipment for the hospital, and (3) the hospital is better able to attract and retain qualified physicians. (J.A. 430-31). Respondent admitted below, however, that, if a hospital did not accept the demanded "bundling" arrangement for radiology services, respondent would invoke "sanctions," including terminating the hospital as a Blue Cross participant or cutting off the hospital's cash flow. (J.A. 714.54). Hospitals acknowledged they are coerced by this threat. (J.A. 476-82, 489, 493, 497).

[5] *See* 707 F. Supp. at 713 n.10 (A-15).

tive market—the market for *physicians'* services, in which many "buyers" compete—and instead must provide their services in a market in which one buyer is dominant.

The District Court upheld this arrangement on essentially two grounds, and the Court of Appeals affirmed for the same reasons.[6] With respect to petitioners' Sherman Act § 1 (15 U.S.C. § 1) challenge to respondent's agreement with the hospitals, the District Court ruled that this case was no different from any situation in which a dominant buyer *unilaterally* used its bargaining power to drive a "hard bargain" with a seller.[7] That respondent does not, in fact, act unilaterally, and instead uses its power over the hospitals to secure an arrangement with radiologists that it could not obtain itself, made no difference to the court:

> [T]here is no authority whatever for the proposition that a seller has an *anti-trust* remedy where a buyer insists upon buying his services through an intermediary.

707 F. Supp. at 712-13 (A-14) (emphasis in original).

Second, the District Court rejected petitioners' claims, predicated on § 2 of the Sherman Act (15 U.S.C. § 2),

---

[6] There are two inconsistent opinions of the District Court in this case, by two different judges. The judge to whom the case originally was assigned denied respondent's motion to dismiss, *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 659 F. Supp. 132 (S.D.N.Y. 1987) (A-26), on grounds later rejected by a subsequent judge ruling on respondent's motion for summary judgment. *See Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 707 F. Supp. 708, 712 n.8 (S.D.N.Y. 1989) (A-6, A-14). The Court of Appeals affirmed on the basis of the second judge's opinion. *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 884 F.2d 707 (2d Cir. 1989) (A-3).

[7] *See* 707 F. Supp. at 713 (A-16) ("Blue Cross is simply acting as a rational buyer attempting to get the best possible terms for its subscribers.")

that respondent was using its market power in the hospital service market improperly to maintain its monopoly in that market (by enhancing the attractiveness of its Blue Cross coverage), and as "leverage" to secure an unlawful competitive advantage in *another* market (the physician service insurance market). The court again ruled that respondent had not used its market power in the hospital service market improperly, and it rejected petitioners' monopoly "leveraging" argument on the ground that, by essentially withdrawing radiology services from the physician service insurance market altogether, respondent had not used its bargaining power to gain any unfair advantage in that market.[8]

REASONS FOR GRANTING THE WRIT

There are two important reasons why this Court should grant the petition for certiorari. First, the decisions of the courts below represent a collision of two importantly distinct lines of antitrust authority: a line firmly prohibiting agreements designed to merge or "bundle" two distinct product markets at the expense of fair competition in those markets, and a line generally permitting a dominant buyer's *unilateral* use of its market power to achieve a favorable bargain in the marketplace. While respondent lawfully may be entitled to drive any bargain it unilaterally can reach with either the hospitals or the radiologists (subject only to restraints against predatory conduct or abuse of market power), it may not combine with *other* parties (here, the hospitals), and compel *them* to secure an agreement with the radiologists that respondent could not obtain itself. The question of law presented is important and unsettled—as evidenced by the two inconsistent opinions of the District Court in this very case—and should be resolved by this Court.

---

[8] *See* 707 F. Supp. at 716 (A-21) ("Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield—none of them pays for radiology services for patients with Blue Cross coverage.")

Second, this case presents the important question of the lawfulness, under § 2 of the Sherman Act, of a monopolist's use of its market power in *one* market to obtain a distinct competitive advantage—but not necessarily a monopoly—in another market. The Courts of Appeals are sharply divided over the lawfulness of so-called monopoly "leveraging." This Court should grant the petition to resolve this important conflict.

I. THE DECISIONS BELOW IGNORE THE CRITICAL DISTINCTION ESTABLISHED BY THIS COURT BETWEEN UNILATERAL AND COLLECTIVE ACTION AND ENDORSE AN IMPROPER EXERCISE OF MARKET POWER.

The District Court essentially ruled that the allegations in the complaint failed to state a claim under the antitrust laws.[9] Thus, the court saw no conceivable antitrust violation in the "bundling" arrangement demanded by respondent and compelled solely through its monopoly power in the hospital service insurance market.

The potential anti-competitive impact of this type of business arrangement—which can be characterized both as a type of group boycott and as a tying arrangement—is firmly established in this Court, subject in certain circumstances even to *per se* prohibition. For example, in *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), the Court held that a complaint that the defendant had used "monopolistic buying power" to bring about a concerted refusal by manufacturers and distributors to deal with the plaintiff stated a claim under the antitrust laws. The Court emphasized:

> This is not a case of a single trader refusing to deal with another, nor even of a manufacturer and a

[9] Although the court granted respondent's motion for summary judgment, it ruled that the judge to whom the case originally was assigned erred in denying respondent's motion to dismiss for failure to state a claim. See 707 F. Supp. at 712 n.8 (A-14).

> dealer agreeing to an exclusive distributorship. Alleged in this complaint is a wide combination consisting of manufacturers, distributors and a retailer.

359 U.S. at 212-213 (footnote omitted).[10] Similarly, in *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2, 13-14 (1984), this Court noted that it had condemned "tying" arrangements in which a seller had used "some special ability—usually called 'market power'—to force a purchaser to do something that he would not do in a competitive market."

The "bundling" requirement at issue here has attributes of each of these condemned agreements. Respondent has used its "monopolistic buying power" to coerce hospitals to refuse to deal with radiologists who insist on practicing as "independent contractors" when treating Blue Cross subscribers and who thereby would "sell" their services in the more competitive *physician* service insurance market. Respondent's use of the hospitals, over which it exercises substantial control,[11] to secure this arrangement is critical: respondent lacks sufficient power over the *radiologists* to achieve the same result directly. The hospitals, on the other hand, provide facilities essential to the radiologists.

Similarly, respondent's insistence on "bundling" hospital services and professional radiology services has all the characteristics of an improper "tying" agreement. In *Jefferson Parish*, this Court recognized that distinct product markets exist for hospital services and the services of anesthesiologists, 466 U.S. at 22-25; the same conclusion is inescapable for the professional services of

---

[10] *See also Mandeville Island Farms v. American Crystal Sugar Co.*, 334 U.S. 219 (1948) (allegation of a conspiracy among large buyer/refiners of sugar beets to set purchase prices stated a claim under the Sherman Act).

[11] *See* n.4, *supra*.

radiologists.[12] While an invalid "tying" arrangement was *not* found in *Jefferson Parish* because consumers had the option of going to another hospital, and thus were not "forced" to purchase the tied product, in this case respondent has used its market power to coerce *all* hospitals in the downstate New York area to bundle hospital and radiology services. As a result, the business of insuring radiology claims is provided *only* by respondent; other insurers virtually are foreclosed from the market.[13]

The District Court did not perceive the blatant impropriety of respondent's "bundling" arrangement because it believed this case to be indistinguishable from a series of cases rejecting challenges by physicians to "balance billing" prohibitions imposed by major insurers. 707 F. Supp. at 711 (A-11); *see e.g., Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 675 F.2d 502 (2d Cir. 1982); *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985); *Brillhart v. Mutual Medical Insurance*, 768 F.2d

---

[12] Moreover, just as "distinct product markets" within the meaning of *Jefferson Parish* exist for hospital services and certain hospital-based physician services (such as professional radiology services), distinct product markets exist for the *insurance* of claims for hospital services and these physicians' services. Indeed, respondent is a dominant provider in one market, while substantial competition exists in the other.

[13] Respondent's merger of hospital and radiology services comes at the expense of both other insurers of *physician* services, who are foreclosed from the business of insuring claims for radiology services, and radiologists, who legitimately would benefit from the ability to offer their services in a market with more than one "buyer." Indeed, the obvious impropriety of respondent's "bundling" arrangement is evidenced by the fact that no other insurance carrier in the country "bundles" hospital and radiology services and thereby attempts to block radiologists from practicing as independent contractors. *See* n.3, *supra*.

196 (7th Cir. 1985); *Barry v. Blue Cross of California*, 805 F.2d 866 (9th Cir. 1986).[14]

In the "balance billing" cases, the insurer requires that, if a physician chooses to "participate" in the insurance program (and thereby receive the benefits of convenient access to a large client base and direct reimbursement from the insurer), the physician must agree to accept a limited, defined rate as full payment for the services provided. Two features of these arrangements are essential. First, the "balance billing" cases involve the *unilateral* exercise of bargaining power by a single major "purchaser" to obtain price concessions directly from physicians, who "sit on [the] opposite sid[e] of the bargaining table." *Royal Drug Co. v. Group Life and Health Insurance Co.*, 737 F.2d 1433, 1438 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985). Second, a competitive market may continue to operate, in that, if the insurer sets the reimbursement rate too low, enough physicians ultimately will choose not to "participate"—even at the expense of a potential loss of a significant client base—and thereby deprive the program of its attractiveness to consumers.

Both of these features are absent in the instant case. Because respondent does not have market power over the radiologists, it has chosen not to negotiate directly with them to attempt to secure this business or the rate it desires. Rather, respondent has *combined with hospitals* and induced *them* to refuse to deal with any radiologist who will not forgo status as an independent practitioner. In addition, because respondent does not deal with or possess market power *over the radiologists*, petitioners have no opportunity to check that market power through the bargaining process.

---

[14] Cf. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

Other cases have recognized the crucial distinction between an insurer's *unilateral* exercise of bargaining power over physicians with whom it bargains, and improper *collective* action designed to achieve the same result.[15] Indeed, in this very case, the District Judge to whom the case originally was assigned rejected the "balance billing" cases because

> the buyer (Empire) has no contractual relations with the sellers (the Radiologists) and has not negotiated for any. Rather, the crucial agreement here, whereby Empire allegedly compels the hospitals to prevent the direct billing of Blue Cross subscribers for the Radiologists' diagnostic services, is between Empire and the hospitals, *not* Empire and the Radiologists.

659 F. Supp. at 135 (A-32). Similarly, the court in *Kartell v. Blue Shield of Massachusetts*, *supra*, distinguished the *unilateral* balance billing situation from a case in which an insurer acts as "a 'third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains." 749 F.2d at 924.

The District Court in this case rejected what it regarded as *Kartell*'s "jocular reference to a sinister 'third force.'" 707 F. Supp. at 712 (A-14). What the court failed to recognize is that it is this "third force" that converts *unilateral* to *concerted* action. And, as first es-

---

[15] This Court has never addressed the substantive antitrust issues raised in the "balance billing" cases, and, in particular, the potential limits on the *unilateral* exercise of market power by a dominant purchaser in the balance billing context. *See, e.g.*, discussion in *Kartell, supra*, 749 F.2d at 927-930. Because this case presents the type of concerted action that always has been unlawful under § 1 of the Sherman Act (and that may form the predicate for an "improper" use of monopoly power under § 2 of the Act), there is no need to consider here the proper limit on the *unilateral* exercise of market power.

tablished in an early antitrust decision of this Court, "[a]n act harmless when done by one may become a public wrong when done by many, acting in concert, for it then takes on the form of a conspiracy, and may be prohibited or punished, if the result be hurtful to the public, or to the individual against whom the concerted action is taken." *Grenada Lumber Co. v. Mississippi*, 217 U.S. 433, 440-41 (1910); *see also Eastern States Retail Lumber Dealers' Assn. v. United States*, 234 U.S. 600, 614 (1914).[16]

This case is not about petitioners' right to balance-bill patients. What is at issue here is concerted action in which respondent uses its market power over *hospitals* to garner insurance business in another market that it could not obtain on the merits. That arrangement harms other insurers competing for business in that market, it harms radiologists who are foreclosed from offering their services in a competitive environment, and it ultimately may harm consumers.[17]

---

[16] A finding of concerted action is not foreclosed here because the hospitals may have acted involuntarily. *United States v. Paramount Pictures, Inc.*, 334 U.S. 131, 161 (1948); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968); *Calnetics Corp. v. Volkswagen of America, Inc.*, 532 F.2d 674, 682 (9th Cir.), *cert. denied*, 429 U.S. 940 (1976).

[17] In rejecting petitioners' antitrust claims, the District Court placed undue reliance on a statement by petitioners that radiologists could obtain an additional $25 million, at the expense of consumers, if not for respondent's "bundling" requirement. There is no guarantee, of course, that any "favorable bargain" improperly achieved by respondent will be passed on to consumers. *See* R. Posner & F. Easterbrook, *Antitrust* 4-10, 148-150 (1981). If $25 million is the amount of money petitioners legitimately could obtain in a competitive market of many insurer/buyers, rather than a market *improperly* dominated by a single insurer/buyer, the antitrust laws do not foreclose relief. In *Mandeville Island Farms v. American Crystal Sugar Co.*, *supra*, the Court held that a conspiracy among large buyer/refiners of sugar beets to fix purchase prices to the detriment of seller/growers stated a cause of action under § 1 of the Sherman Act, despite the fact that "the persons specially injured . . . are sellers, not customers or consumers," 334 U.S. at

This Court should grant the petition to resolve the confusion in this important area of law, evidenced by the two conflicting decisions of the District Court in this very case, as well as by the inconsistency of this case with *Kartell v. Blue Shield of Massachusetts*, *supra*. In addition, the Court should not allow respondent's novel "bundling" requirement, and the erosion permitted by the courts below on the distinction between unilateral and collective action, to become entrenched.

II. THE COURT SHOULD GRANT THE PETITION TO RESOLVE THE CONFLICT IN THE CIRCUITS OVER THE LEGALITY OF MONOPOLY "LEVERAGING."

Apart from the § 1 issue presented by respondent's agreement with and use of the hospitals to coerce radiologists to provide their services to Blue Cross subscribers only through hospitals, this case presents important questions concerning the permissible use of market power under § 2 of the Sherman Act. It is indisputed that respondent was able to secure its "bundling" arrangement only through its market power in the *hospital* service insurance market. It did so for either (or both) of two reasons: either to maintain its monopoly in the hospital service insurance market, or to secure business in the *physician* service insurance market that it could not obtain on its own merits.[18] Use of market power for either reason is unlawful.

235, and the reduced purchase prices could have benefited consumers. Similarly, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), this Court held that a schedule of *maximum* fees set by competing physicians constituted a *per se* violation of the Sherman Act, rejecting the claim that a maximum fee schedule only could benefit consumers. *Id.* at 348.

[18] Minutes of respondent's board meetings disclose that its "bundling" requirement was motivated solely by concern that any other practice would "reduce the value of our product and imperil our market share." (J.A. 555). As further stated in the minutes:

It is firmly established under § 2 of the Sherman Act that a monopolist may not use improper means to maintain an existing monopoly lawfully acquired. *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985); *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951). In this case the District Court assumed that "Blue Cross uses its market power to obtain favorable prices from hospitals," 707 F. Supp. at 715 (A-20), but, again relying erroneously on the balance billing cases, it viewed respondent merely as a buyer negotiating a good price or specifying what it would buy. *Id.* A similar question is presented under § 2, therefore, as that presented under § 1: is respondent's coercive use of the *hospitals* to obtain agreements with *physicians* that respondent could not otherwise obtain a proper use of monopoly power?

This case also presents a distinct and important question under § 2 of the Sherman Act. Respondent has used its monopoly in the hospital service insurance market to obtain a virtually exclusive franchise to provide coverage for professional *radiology* services, which in all other parts of the country is provided by insurers of *physicians'* services in a competitive payor marketplace. Thus, respondent has used its monopoly in one market to gain a distinct and substantial advantage that it otherwise would not enjoy—but not necessarily a monopoly—in another, competitive market.

There is authority that such monopoly "leveraging" is unlawful. In *Berkey Photo v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980), the court unequivocally stated:

> [T]he use of monopoly power attained in one market to gain a competitive advantage in another is a violation of § 2, even if there has not been an attempt

---

"The ultimate question comes down to whether we can continue to include these costs under the Blue Cross contract or abandon the field [of medical insurance] to others?" *Id.*

> to monopolize the second market. It is the use of economic power that creates the liability.

This principle more recently was expounded in *Kerasotes Michigan Theatres v. National Amusements*, 854 F.2d 135 (6th Cir. 1988). The court firmly accepted the proposition that, "[t]o run afoul of the antitrust laws, it is not necessary that the party attempting to leverage its monopoly power from a given market into a second market possess monopoly power or a dominant market position in that second market," *id.* at 137, and explained:

> Products that may be inferior should not be allowed to prosper in a particular market as a result of its producer's exploitation of its monopoly position in a second market. Under such situations, potential economic or competitive gains are not identifiable.

Id. at 138.

Other circuits, however, have explicitly questioned or repudiated this doctrine. *See Catlin v. Washington Energy Co.*, 791 F.2d 1343, 1346 (9th Cir. 1986); *Fishman v. Estate of Wirtz*, 807 F.2d 520, 541 n.18 (7th Cir. 1986); *Association of Intercollegiate Athletics for Women v. National Collegiate Athletic Assn.*, 735 F.2d 577, 586 n.14 (D.C. Cir. 1984); *Consul v. Transco Energy Co.*, 805 F.2d 490, 494 & n.11 (4th Cir.), *cert. denied*, 481 U.S. 1050 (1986).

The District Court in this case denied that any monopoly "leveraging" was present. It concluded that "Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield—none of them pays for radiology services for patients with Blue Cross coverage." 707 F. Supp. at 716 (A-21). There are two gross flaws with this analysis.

First, the court's analysis misperceives the identity of Blue Cross and Blue Shield—which merely are different products offered by a single entity, respondent. The point is that *respondent* benefits economically through the acquisition of insurance business it otherwise would lose in

the competitive physician service insurance market. Second, the court viewed respondent's action as providing equal cost *savings* to Blue Shield and other physician service insurers. If such cost savings indeed were a *benefit* to others—as perceived by the District Court—there would be no reason why respondent (through its Blue Cross coverage) voluntarily would inflict all such costs upon itself. The point here again is the garnishment of insurance business, which, while entailing *costs*, entails costs that presumably are recouped through other revenues.

This case thus presents a classic example of monopoly "leveraging." While respondent has not acquired a monopoly in the physician service insurance market, it has secured a greater *share* of that market *than it could obtain on the merits* through use of its monopoly power in the hospital service market. This Court should grant the petition to clarify the permissible use of monopoly power under § 2 of the Sherman Act, and in particular to resolve the express conflict existing in the circuits over the monopoly "leveraging" doctrine.

CONCLUSION

For all the foregoing reasons, and for those set forth in the petition for certiorari, the petition for certiorari should be granted.

Respectfully submitted,

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record